2003 INSURANCE LAW DEVELOPMENTS

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INTRODUCTION

2003 was a momentous year for insurance law in California. Insurance reform was at the forefront of the Legislature's agenda. The result was enactment of historic legislation in three areas. In addition, California appellate courts and the Ninth Circuit issued a number of decisions also of great import to insurers operating in the state.

In August, 2003, the Legislature enacted Senate Bill 1, which provides the strictest set of privacy controls on financial institutions of any state in the country. As a result, California insurers are confronted with a number of significant challenges and unique implementation issues, especially in light of the statute's interface with the privacy regulations promulgated by the California Department of Insurance to carry out requirements under the federal Gramm-Leach-Bliley Act.

The Legislature then turned its focus on enacting reforms of California's troubled workers' compensation insurance system. The Legislature enacted a package of sweeping measures, primarily directed at reducing California's relatively high -- and increasing -- claims costs, in the hope of reducing the sharply escalating premiums that employers have been facing throughout the state.

There is a general consensus that the workers' compensation insurance reforms will result in billions of dollars of cost reductions. However, the reforms have generated much debate and uncertainty over the amount of actual cost savings that will be realized, and therefore, the extent to which premiums will be reduced. The newly-elected Republican Governor is insisting on further legislation to reduce the cost of claims, under the threat of otherwise supporting a ballot measure that will impose such reforms. Meanwhile, others in the Democrat-controlled Legislature are urging legislation that would authorize greater regulation to prevent the charging of "excessive" workers' compensation rates in light of the cost savings measures already enacted.

The Legislature followed this historic reform package with the late year enactment of perhaps the most far-reaching legislation in the health insurance field ever enacted in this state. Senate Bill 2 , known as "Pay or Play," requires employers with more than 20 employees to provide health insurance coverage for their employees, or pay a fee to the state to provide such coverage. The mandate would commence in 2006 for certain size employers, and 2007 for others. This legislation too has generated great controversy, and various business interests are working to repeal it.

Finally, throughout this year of historic legislative enactments, state and federal appellate courts have issued significant opinions concerning a wide variety of insurance law issues, including issues relating to the "pollution exclusion," "advertising injury," "excess coverage," the "duty to defend," and "bad faith" claims.

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CALIFORNIA INSURANCE PRIVACY LAW DEVELOPMENTS

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2003 proved to be another active year for insurers on the privacy compliance front. The two major developments that insurers have to contend with are the California Insurance Department privacy regulations and Senate Bill 1, the California Financial Information Privacy Act.

California Insurance Department Privacy Regulations

In March of 2003 the California Department of Insurance finalized its regulations (the alifornia Insurance Privacy Regulations implementing the privacy notice and opt-out notice requirements mandated by Title V of the federal Gramm-Leach-Bliley Act (LB . These regulations (California Insurance Department Regulations Sec. 2689.1 et seq.), which were intended to supplement the California Insurance Code privacy statute (Cal. Ins. Code Sec. 791 et seq.), are based largely on the model privacy regulation promulgated by the National Association of Insurance Commissioners in 2000 (the AIC Model Privacy Regulation . However, the California Insurance Privacy Regulations, while largely similar to the NAIC Model Privacy Regulation, also contain their own unique requirements, which essentially means that insurers must develop a special privacy notice just to conform to the California-specific requirements, or else modify their nationwide notices to comply with the California mandates.

These unique requirements include such things as objective readability standards. Under the California Insurance Privacy Regulations, privacy notices must not only be in a clear, readable font no smaller than 10 points, but they also must achieve a Flesch Readability Index score of at least 50 (on scale of 100). The California Insurance Privacy Regulations also require special disclosures in privacy notices that other states do not mandate. For example, for companies that do a separate California privacy notice and a national notice, the Regulations require that the California notice state that California consumers rights are not limited by the terms of the insurer non-California privacy notices.

The California Insurance Privacy Regulations also contain a number of special provisions applicable to the form and content of opt-out notices for those licensees that choose to share nonpublic personal information with unaffiliated third parties outside of the categories of exempt disclosures recognized under the California Insurance Code privacy statute. One key point to note here is that the California Insurance Department, unlike the NAIC in its Model Privacy Regulations, does not recognize any oint marketing exemption from its prohibitions on the sharing of nonpublic information with third parties. In other words, insurers that plan to market a product or service under a joint marketing agreement with an unaffiliated party generally cannot share the nonpublic information of their California customers without first giving the customer an opportunity to opt out by directing the insurer not to share such information.

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Senate Bill 1

Although in a number of respects the California Insurance Privacy Regulations imposed stricter standards on insurers than the privacy laws of most other states, key members of the California legislature had for some time been pushing to enact legislation that would provide even more comprehensive protection for California consumers in their dealings with insurers and other financial institutions. These efforts finally came to fruition in August of 2003, with the passage of Senate Bill 1, a legislative measure that provides the strictest set of privacy controls of any state in the country.

Current Law

Presently, California financial institutions--including banks and other depository institutions, securities firms and insurance companies and insurance producers--may, in general, share without restriction nonpublic personal information regarding their customers with affiliated entities, but may not (except under certain circumstances) share such information with unaffiliated entities unless they first give the consumer an opt-out right, and the consumer does not exercise this opt-out right by directing the financial institution to refrain from sharing the consumer information. In addition, financial institutions are required annually to provide their customers with a notice describing the categories of personal information they collect, the types of information they share with affiliated and unaffiliated third parties, and the general purposes of such disclosures. An opt-out form must be included with such annual notices if the financial institution wishes to share nonpublic personal information with unaffiliated entities (unless such disclosures fall within a prescribed list of exceptions). In addition, insurance companies and other insurance licensees are required to provide policyholders an insurance information practices notice describing, among other things, the types of private information they obtain from third parties and the policyholder right to review and correct the information the insurer maintains in its records about them.

Major Impact of Senate Bill 1

Codified as Division 1.2 of the California Financial Code (California Fin. Code 4050 et seq.), Senate Bill 1 is designed to tighten significantly the ability of financial institutions to share nonpublic personal information regarding consumers resident in California in two principal ways. First, in general, it will require that in order for a financial institution to share such information with unaffiliated entities, the financial institution must first obtain the consumer affirmative written consent (referred to as an pt-in . Second, Senate Bill 1 generally prohibits financial institutions from sharing such information even with affiliated entities unless they first provide an opportunity for their customers to opt out of such information sharing. As one might expect, there are a host of exceptions and qualifications to these two general rules, some of which are explained below. Moreover, it is presently unclear how the new rules set forth in Senate Bill 1 are to be reconciled with the California Insurance Code privacy statute (Civil Code 56.10 et seq.) and the California Insurance Privacy Regulations. However, there is no question that insurers and other financial institutions will need to begin reviewing their operations and procedures now in light of this new California legislation so that they will be able to

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make the necessary adjustments to be compliant by July 1, 2004, the date the law is scheduled to become effective.

Scope of Legislation

Senate Bill 1 applies to onsumers - California residents who obtain financial products or services primarily for personal, family or household purposes from a inancial institution, which is generally defined the same as in GLB, subject to certain clarifying exemptions applicable to technology vendors, professional service firms such as attorneys, and automobile dealers that originate installment sale or lease contracts and sell them within 30 days to a financial institution. Nonpublic personal information (PI is another key definition in the legislation that, while generally consistent with GLB and related regulations, also includes certain unique provisions as well.

Interestingly, one area in which Senate Bill 1 appears narrower than GLB and related regulations is that it does not seem to cover individuals who have applied for or inquired regarding a financial product or service but have not yet become customers of a financial institution. Nor does Senate Bill 1 cover a life insurance beneficiary, or a claimant under a commercial liability insurance policy, both of whom would be considered consumers under the California Insurance Privacy Regulations if their NPI is shared with non-affiliates outside of the exemptions permitted in the California Insurance Code privacy statute.

Sharing of NPI with Non-Affiliates

As noted above, the general rule set forth in Senate Bill 1 is that a financial institution may not share NPI of a consumer with a non-affiliated entity unless it has received an affirmative written consent, or opt-in, from the consumer. The bill contains detailed rules as to the form the consent must take in order to be valid. Among these rules is a requirement that the opt-in form be a physically separate document, and must be dated and signed by the consumer. Although the legislation allows a financial institution to offer incentives or discounts to induce a consumer to provide such consent, it may not discriminate against a consumer who does not provide such consent by withholding products or services from such consumer.

Sharing of NPI with Affiliates

In contrast to the sharing of NPI with non-affiliates, where the consumer affirmative opt-in is required, Senate Bill 1 allows financial institutions to share NPI of consumers with affiliated entities only if the financial institution has clearly and conspicuously notified the consumer annually in writing that their information may be disclosed to an affiliate and the consumer has not opted out by directing that such information not be disclosed. As with the opt-in rule for non-affiliate sharing, a financial institution will be allowed to offer incentives or discounts for those consumers who decide not to exercise their opt-out right, but cannot discriminate against a consumer who does decide to opt out.

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Senate Bill 1 contains detailed specifications for the opt-out forms that must be used. A financial institution can either create its own opt-out form following these specifications or, alternatively, use the sample afe harbor form that is included in the legislation. If the financial institution uses the safe harbor form, it will be conclusively presumed to have met the statutory opt-out form requirements. On the other hand, if a financial institution designs its own opt-out form, it must file the form with its unctional regulator (e.g., the California Department of Insurance or Department of Financial Institutions) for approval, and must also file the form with the California Office of Privacy Protection within 30 days of using the form. Approval of the opt-out form by the functional regulator constitutes a rebuttable presumption that the form complies with the statutory requirements.

Senate Bill 1 also specifies how opt-out notices are to be sent, and what opt-out response options a financial institution must make available to its customers. Contrary to the regulations promulgated by state and federal agencies under GLB, Senate Bill 1 does not appear to allow a financial institution to combine its GLB privacy notice on the same form as the statutory opt-out notice for sharing of NPI with affiliates. Although they can be included in the same mailing, the opt-out notice must be a separate form from the GLB privacy notice. Moreover, the financial institution must include the phrase MPORTANT PRIVACY CHOICES in 16-point boldface type on the outside of envelopes containing the opt-out notice, unless the notice is also sent with a bill or other statement of account, or with an application requested by the consumer.

Moreover, if the opt-out notice is included with any other type of mailing, it must be the first page of the mailing. Financial institutions having assets over $25 million must include (1) a self-addressed first class business reply envelope with the notice, or (2) a self-addressed return envelope and at least two alternative cost-free means for consumers to respond (such as a toll-free telephone number, email address or web site). Smaller entities need only include a self-addressed return envelope, but need not provide prepaid postage. In addition to mailed and physically delivered notices, the legislation also allows for delivery of opt-out notices by electronic means, provided the special rules applicable to electronic notices set forth in the rule are followed.

As discussed further below, there is a significant question as to whether any of the provisions of Senate Bill 1 relating to the sharing of NPI with affiliates are enforceable, given the broad preemption provisions contained in the federal Fair Credit Reporting Act that prevent states from imposing any requirement or prohibition with respect to the exchange of information among persons affiliated by common ownership or control. Until the enforcement posture of the California Department of Insurance and other California financial institution regulators becomes clearer, financial institutions will need to proceed with caution in this area.

Joint Marketing Arrangements

Senate Bill 1 treats joint marketing arrangements between unaffiliated financial institutions as essentially akin to arrangements among two affiliated entities. Although GLB provides an exemption from opt-out requirements for joint marketing arrangements,

the new California legislation will require a financial institution to provide an opt-out opportunity to the consumer in compliance with the opt-out rules for affiliate information sharing discussed above. If the consumer does not opt out, then the financial institution may share the NPI of its consumers with the non-affiliate to facilitate the joint marketing arrangement. Moreover, the bill contains a special dispensation for joint marketing arrangements that were in place prior to January 1, 2004. For these arrangements, the participating financial institutions need not comply with the bill opt-out notice rules until January 1, 2005.

It is presently unclear how this special grandfathering provision for joint marketing arrangements will apply to joint marketing arrangements involving an insurance company, given the California Insurance Department view that there is no joint marketing exemption under the privacy provisions of the California Insurance Code. Absent reconciling legislation, it is possible that despite the grandfathering provision discussed above, an insurer will still be prohibited from disclosing NPI to an unaffiliated financial institution without providing an opt-out opportunity that, at the very least, complies with the opt-out requirements set forth in the California Insurance Code.

Special Rule for Wholly-Owned Affiliates in the Same Line of Business

In an apparent attempt to create a level playing field between financial institutions that operate through separate business units or divisions of the same corporation and other financial institutions that divide such functions among separately incorporated affiliates, Senate Bill 1 allows the unrestricted sharing of NPI between a financial institution and its wholly owned (direct or indirect) subsidiary; among financial institutions that are each wholly owned by the same financial institution; among financial institutions that are wholly owned by the same holding company; or among the insurance and management entities of a single insurance holding company system consisting of one or more reciprocal insurance exchanges which has a single corporation or its wholly owned subsidiaries providing management services to the reciprocal insurance exchanges.

However, in order for this exemption to apply, all of the following conditions must be met: (1) the isclosing and eceiving financial institution must be regulated by the same unctional regulator (insurers admitted to do business in California will be considered to have satisfied this requirement); (2) the two institutions must be in the same ine of business (for these purposes there are only three: banking, securities or insurance); and (3) the two institutions must share a common brand (more than just a common logo or symbol) within their trademark, service mark or trade name.

Exempted Categories of Disclosures

In order to facilitate some degree of coordination with GLB, Senate Bill 1 recognizes a number of categories of exempt disclosures, i.e., circumstances in which a financial institution may disclose NPI of its consumers to affiliates or non-affiliates without complying with the opt-in or opt-out rules. Many of these exemptions are very similar, although not identical, to those set forth in GLB and in the state and federal

regulations promulgated pursuant to GLB, including, for example, disclosures ecessary to effect, administer or enforce a transaction requested or authorized by the consumer; disclosures to facilitate law enforcement and fraud prevention; and disclosures to regulators, rating agencies, and auditors.

The legislation also contains special exemptions for insurance producers who are seeking insurance quotes on behalf of their clients, and treats exclusive or captive agents as essentially employees of the insurance company they represent, so that the insurer may share NPI with it exclusive agents generally to the same extent such information may be shared with its actual employees.

The bill also contains a special hared data storage facility exemption for affiliated entities in that it provides that a financial institution will not be deemed to have disclosed information to its affiliate merely because information is maintained in common information systems or databases, and employees of the financial institution and its affiliate have access to those common information systems or databases, or a consumer accesses a web site jointly operated or maintained under a common name by or on behalf of the financial institution and its affiliate.

Penalties and Enforcement

Under the bill, an entity that negligently discloses or shares nonpublic personal information will be liable for civil penalties not to exceed $2,500 per violation or $500,000 in the aggregate. For intentional violations there is no cap on the aggregate penalties that may be assessed. For violations that lead to identity theft, as defined in the California Penal Code, the penalties are doubled. These civil penalties may be sought only by the California Attorney General or by the functional regulator of the financial institution in California.

Reconciliation with Other Laws and Regulations

As with any new piece of legislation, particularly in the area of privacy where there are so many different laws and regulations at both the state and federal level, there are a number of potential areas of conflict and ambiguity that financial institutions will face in trying to restructure their privacy compliance programs to meet the bill requirements. Some of these areas will perhaps be dealt with in the coming months by California unctional regulators of financial institutions, such as the California Insurance Department and Department of Financial Institutions. One area of potential conflict that was expressly addressed in the legislation was the various municipal and county privacy ordinances in California that purport to impose full opt-in requirements for data sharing with both affiliates and non-affiliates. Under the legislation, these local ordinances are preempted, both retroactively and prospectively. Nevertheless, other areas of conflict and uncertainty remain, and financial institutions will need to carefully review their compliance programs to determine what changes they will need to make, if any, to address these mandates.

As noted previously, a further complicating factor is the likely vulnerability of the affiliate sharing provisions of Senate Bill 1 to claims that they are preempted by the federal Fair Credit Reporting Act (CRA . Among the state preemption provisions of FCRA--all of which were permanently reauthorized by Congress in December of 2003--is Section 625(b)(2), which states that no requirement or prohibition may be imposed under the laws of any state with respect to the exchange of information among persons affiliated by common ownership or corporate control. (See 15 U.S.C. 1681t(b)(2)). The affiliate sharing restrictions of California Senate Bill 1 would seem to fall squarely within this preemption provision, and thus arguably are unenforceable. However, it is presently unclear whether litigation will be necessary to remove the threat of their enforcement by the California Insurance Department and California other financial institution regulatory agencies.

Financial institutions doing business in California should begin planning now as to how they will address the new requirements imposed by Senate Bill 1. Although the law will not become effective until July 1, 2004, it will mean sweeping changes for many institutions, which will need to analyze not only how these mandates will impact their California operations and compliance obligations, but also their privacy compliance activities in other states.

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DEVELOPMENTS IN CALIFORNIA INSURANCE LAW: WORKERS COMPENSATION REFORM

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INTRODUCTION

In 2003, the State Legislature enacted major reforms to California workers compensation system in response to a crisis of increasing claims costs and premiums. This crisis developed from a confluence of factors during the ten years following the repeal of the state minimum rate law: (1) fierce price competition developed among insurers; (2) steadily increasing health care costs; (3) statutory expansion of workers compensation benefits; (4) utilization of medical services by California claimants that vastly exceeded the national average; (5) premiums being charged below the amount paid out for claims; (6) the insolvency of dozens of insurance companies and the abandonment of the California market by other insurers; (7) the increasing market share of the State Compensation Insurance Fund; (8) the financial impact on the California Insurance Guaranty Association ("CIGA"), the state-created entity that pays claims of insolvent insurers; and (9) the eventual skyrocketing of premiums paid by California businesses, which are among the highest in the nation.

The 2003 reform legislation addresses three main areas of concern: (1) providing CIGA with the liquidity to continue paying the claims of insolvent insurers; (2) reducing costs in the workers compensation system, mostly through control of medical costs and prevention of over-utilization of medical services; and (3) attempting to ensure that insurance companies pass resulting cost savings on to employers.

CIGA & INSOLVENCY

As a result of charging low premiums while facing increasing health care costs, many workers compensation insurers in California became insolvent. CIGA is directed by statute to pay claims of insolvent insurers. In the last several years, CIGA has paid out more on claims to injured workers than it has collected in surcharges from the solvent insurers. The 2003 reform legislation includes the following provisions to address CIGA cash flow problems:

- Authorizes the California Infrastructure and Economic Development Bank to issue bonds on behalf of CIGA to finance the costs of claims of insolvent workers compensation insurers. (A.B. 227, Gov. Code 63049.62, 63049.64, 63071.)

- Expands the statutory definition of nsolvency to include: n inability of the insurer to meet its financial obligations when they are due. nsolvency previously was defined only as ny impairment of minimum paid-in capital. The change should make it easier to place troubled insurers into conservatorship. (A.B. 227, Ins. Code 985.)

- Allows for Special Assessments against solvent workers compensation insurers to repay the bonds; retains current rules allowing surcharge to insureds. (A.B. 227, Ins. Code 1063.14, 1063.145, 1063.74.)

- Provides that a maximum of $1.5 billion in bonds may be outstanding at anytime, that all bonds must be issued prior to Jan. 1, 2007, and that all bonds shall have a final maturity of twenty years or less. (A.B. 227, Ins. Code 1063.75.)

COST SAVINGS

The Legislature determined that workers compensation premiums could be reduced significantly if various cost control measures were put into place. Significantly, the Legislature found that injured workers in California paid more for similar medical services and utilized those services at greater rates than comparable injured workers in other states. The 2003 reform legislation contains several provisions designed to control costs in the system:

1. Combating Fraud

- Increases the fine for workers compensation fraud from $50,000 or double the value of the fraud to $150,000 or double the value of the fraud, whichever is greater. (A.B. 227, Ins. Code 1871.4.)

- Specifies adoption of new fraud protocols and requires insurers, employers, administrators, attorneys, administrative law judges to report all suspected workers compensation fraud. (S.B. 228, Labor Code 139.4, 139.45.)

1. Vocational Rehabilitation Benefit

- Repeals sections dealing with vocational rehabilitation and adds a new section providing nontransferable vouchers in amounts from $4,000 to $10,000 to be used for ducation-related retraining or skill enhancement. Applies to injuries on or after Jan. 1, 2004. (A.B. 227, Labor Code 139.5, 4658.5, 4658.6.)

1. Limitation On Physical Therapy / Chiropractor Visits

- Notwithstanding any other provisions, n employee shall be entitled to no more than 24 chiropractic and 24 physical therapy visits per industrial injury. (S.B. 228, Labor Code 4604.5(d).)

1. Medical Treatment Utilization Guidelines

- Commissions a study of vidence-based, peer-reviewed nationally recognized standards of care, including existing medical treatment utilization standards . . . for the purpose of the adoption of a medical treatment utilization schedule. (S.B. 228, Labor Code 77.5.)

- Requires the adoption of a medical treatment utilization schedule on or before Dec. 1, 2004. (S.B. 228, Labor Code 5307.27.) Provides that upon adoption of a utilization schedule, such schedule shall be resumptively correct on the issue of extent and scope of medical treatment unless rebutted y a preponderance of the evidence. (S.B. 228, Labor Code 4604.5(a), 5307.27.)

- Until a utilization schedule is adopted, the American College of Occupational and Environmental Medical Practice Guidelines are deemed presumptively correct unless rebutted by a preponderance of the evidence. (S.B. 228, Labor Code 4604.5(c).)

- If a particular injury is not listed in the schedule or in the Practice Guidelines, uthorized treatment shall be in accordance with other evidence based medical treatment guidelines generally recognized by the medical community. (S.B. 228, Labor Code 4604.5(g).)

- Requires every employer to stablish a utilization review process governed by written policies and procedures that ensure decisions are based on the edical necessity to cure and relieve and are onsistent with the schedule for medical treatment utilization. (S.B. 228, Labor Code 4610.)

1. Medical Fee Schedule / Caps To Medicare, Including Outpatient Services

- Repeals the current medical fee schedule procedures, and replaces them with a new Section requiring the adoption and periodic revision of n official medical fee schedule that shall establish reasonable maximum fees paid for medical services. (S.B. 228, Labor Code 5307.1.) Outpatient services will now be included in the schedules. (Id.)

- Provides that all fees shall comply with the tructure and rules of the relevant Medicare and Medi-Cal payment systems. (Id.)

- Caps maximum reasonable fees at 120 percent of Medicare. Provides that if a procedure is not listed on the schedule or in Medicare, the maximum fee shall not exceed 120 percent of Medicare for services that require comparable resources. (Id.)

- Until a new medical fee schedule is adopted, he maximum reasonable fee paid shall not exceed the fee specified in the official medical fee schedule in effect on December 31, 2003. (Id.)

- Commissions an annual study f access to medical treatment for injured workers. Allows adjustments to medical fees based upon the study, and allows for increases to above 120 percent of Medicare if ubstantial access problems exist. (S.B. 228, Labor Code 5307.2.)

1. Prescription Drug Price Cap

- Caps drug prices at 100 percent of fees provided in the Medi-Cal payment system. Provides that if a drug is not listed on the schedule or in Medi-Cal, the maximum price shall not exceed 100 percent of comparable Medi-Cal listed drugs. (S.B. 228, Labor Code 5307.1.)

- Requires ny person or entity that dispenses medicines and medical supplies to dispense the generic equivalent except in limited circumstances. (Prior law applied the requirement only to pharmacies.) (S.B. 228, Labor Code 4600.1.)

1. Roll-Back Of Fees For Physician Services

- Rolls-back all fees for physician services during calendar years 2004 and 2005 by 5% of the rate currently in effect, and allows for further reductions to a maximum reduction equal to the Medicare rate. (S.B. 228, Labor Code 5307.1(k).)

1. Repeal Of The Treating Physician Presumption

- Largely repeals the treating physician presumption, limiting the presumption to narrower (but unclear) circumstances. n all other cases . . . regardless of the date of injury, no presumption shall apply to the opinion of any physician on the issue of extent and scope of medical treatment, either prior or subsequent to the issuance of an award. (S.B. 228, Labor Code 4062.9, 4604.5(e).)

RATE / PREMIUM PROVISIONS

The media reported much debate in committee over whether to enact provisions that would give the Insurance Commissioner greater power to regulate the rates charged by workers compensation insurers. The final legislation does not include any such provision giving the Commissioner authority to disapprove rates as being "excessive." However, the legislation does include provisions designed to pass any cost savings resulting from the reforms on to employers in the form of rates that are lower than otherwise would be charged:

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- Requires the Insurance Commissioner to take into account the projected savings from the legislation in determining the advisory pure premium rates for policies beginning or renewed on or after Jan. 1, 2004. (A.B. 227, Ins. Code 11735.1(a).)

- Specifies that insurers shall file rates . . . that include the provision for projected savings determined by the insurance commissioner . . . . (A.B. 227, Ins. Code 11735.1(b).)

- Requires that rates nonetheless must comply with Section 11732, which provides that rates shall not be inadequate, unfairly discriminatory, or tend to create a monopoly. (Id.)

- Provides that this Section shall remain in effect only until Jan. 1, 2005. (A.B. 227, Ins. Code 11735.1(c).)

- Changes do not give the Commissioner the authority to disapprove rates that are excessive. As before the 2003 reforms, the Commissioner may only disapprove rates that are inadequate, unfairly discriminatory, tend to create a monopoly, or that do not meet the technical filing requirements. (Ins. Code 11732 et seq.)

- Requires the WCIRB to determine the cost savings achieved by this legislation. (A.B. 227, Ins. Code 11742(d).)

- Requires each insurer to certify that its rates reflect the cost savings determined by the WCIRB. (Id.)[1]

- Requires the Commissioner to post on the Insurance Department's web site a comprehensive insurance rate comparison for the largest 50 workers' compensation insurance writers. (A.B. 227, Ins. Code § 11742(b).)

- Commissions a study and report into "the feasibility of reinstating a minimum rate regulatory structure for the workers' compensation insurance market, to be phased in over a five-year period." (A.B. 227, at SEC. 17(c).)

- Requires the Commissioner to "study and analyze the financial condition, underwriting practices, and rate structure of the State Compensation Insurance

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[1] The requirement that insurers certify rates according to the WCIRB's determination of the cost savings is arguably inconsistent with the requirement that they "shall file" rates that "include the provision for projected savings" determined by the Commissioner. The latter's determination may differ from the former's determination.

Fund" for a report "on the potential of reducing rates by July 1, 2004, and every July 1 thereafter." (S.B. 228, at SEC. 52.5(b).)

MISCELLANEOUS PROVISIONS

A number of other significant reforms were included in the 2003 reform legislation, including the following:

Collective Bargaining To Include Workers' Comp.

· Repeals special collective bargaining rules with respect to aerospace and timber employers and adds a new section allowing collective bargaining agreements to contain workers' compensation terms for all employers over a certain size. Further requires annual reports regarding all labor-management agreements. (S.B. 228, Labor Code § 3201.7.)

1. Objections To Medical Treatment Determinations

· Rewrites the procedure for objections to medical determinations, including how to seek agreements on treatment with injured workers who are and are not represented by counsel. All disputes require a physician report to resolve, and such reports are expressly admissible in further judicial proceedings. (S.B. 228, Labor Code § 4061.)

· Provides a carve-out for spinal surgery, which now requires a second opinion from an orthopedic surgeon to resolve the disputed surgical recommendation. (S.B. 228, Labor Code § 4062(b).) The spinal surgery carve-out expires on Jan. 1, 2007. (S.B. 228, Labor Code § 4062(h).) Commissions a study of the spinal surgery second opinion procedure to be completed by June 30, 2006, to make recommendations for further legislation. (S.B. 228 at Section 48.)

· Specifies that relevant portions of "medical treatment protocols published by medical specialty societies" shall be admissible in appeals board proceedings. (S.B. 228, Labor Code § 5703.)

1. Insurer's Report Of Employers' Injury Prevention Program

· Requires every insurer to conduct a review and written report "of the injury and illness prevention program (IIPP) of each of its insureds within four months of the commencement of the initial insurance policy term." (S.B. 228, Labor Code § 6401.7(*l*).)

Section 6401.7(l) imposes on insurers an obligation to conduct a "review" of each new insured's IIPP within four months of initial policy inception. The review must include a determination of whether the insured has implemented all required IIPP components, and an evaluation of the IIPP's effectiveness. The reviewer

must prepare a written report specifying the findings and recommended changes deemed necessary to make the IIPP effective. The reviewer must be an independent professional licensed engineer, certified safety professional, or certified industrial hygienist. (Id.)

DEVELOPMENTS IN HEALTH INSURANCE LAW

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Pay or Play Legislation

The most far-reaching legislation enacted in the health insurance field, and arguably in the entire legislative session, is Senate Bill 2 (Burton, Dem.-San Francisco). The bill, affectionately known as "Pay or Play," adds a new Part 8.7 to the Labor Code (Sections 2120-2210), to be known as the Health Insurance Act of 2003. It also amends or adds numerous sections in the Health and Safety Code, Insurance Code, Welfare and Institutions Code and Government Code, among others. The bill will require employers in different employment size categories to provide health insurance coverage for their employees. If they do not, then they will be required to pay a fee to the state to provide coverage to employees and some dependents. The coverage provided by employers must meet certain standards of coverage. Such employers must then show proof that they purchased such qualifying coverage. The level of employer contribution is also specified in the statute at 80%, but there are adjustments to this requirement that vary by employer size, dependent coverage and even by the wage level of the employee.

Under the bill, employers with more than 200 employees must offer qualifying coverage to employees and their dependents commencing in 2006. Employers with 20-199 employees would not be subject to the pay or plan mandate until 2007, and those companies would only have to offer employee coverage. Finally, employers with 20-49 employees would be exempted from the mandate until such time as legislation extends the mandate along with a 20% tax credit, and employers with fewer than 20 employees would not be subject to the mandate.

Employers subject to the mandate who do not provide the required insurance will be subject to a fee. The fee is to be set by the Managed Risk Medical Insurance Board, which will also establish and administer the State Health Purchasing Program to provide coverage to the employees and dependents of employers who pay the fee rather than provide coverage.

In addition to the Pay or Play provisions, Senate Bill 2 also contains an extension of small group laws such that the restrictions (guaranteed renewal, risk adjustment factors, etc.) that only apply to groups with between 2 and 50 employees will, in 2006, apply to groups with between 51 and 199 employees as well. With a slight nod to insurers, the bill allows for a different rate band for the "medium employer" products (51-199 employees) -- plus or minus 15% rate bands as opposed to the plus or minus 10% rate bands that apply to small group products.

Senate Bill 2 was and is a controversial piece of legislation. Business and other groups that opposed the legislation are expected to mount a judicial attack on the law. The primary bases are expected to be that the mandate is preempted by federal law under

ERISA and that the fee imposed on non-insuring employers constitutes a tax that was not enacted with the two-thirds majority vote required for California tax legislation. In addition to judicial attacks, opponents are also trying to use a ballot initiative to overturn Senate Bill 2.

Continuity of Care

Two identical bills, AB 1286 (Frommer, Dem.-Los Angeles) and SB 244 (Speier, Dem.-Hillsborough) will expand the categories of patients who are eligible for continuity of care when the contract between a health care service plan or insurer and provider or hospital is either terminated or not renewed. Previously, the law granted such continuity of care protections to patients with acute conditions (as defined), serious chronic conditions (as defined), high-risk pregnancy, or any pregnancy in the second or third trimester. These bills extend those protections to include all pregnancies, terminal illnesses, newborns to age three, and surgeries or other procedures that were authorized before the provider contract termination.

Perhaps one of the most hotly debated subjects during discussion of these bills was reimbursement rates during continuity care following termination. Simply put, plans and insurers must offer providers a rate of compensation that is similar to that which the plans or insurers pay to other providers for the same services in the same area as the terminated provider. If the provider does not accept the rate, the insurer or plan need not provide continuity of care with that provider. Thus, while the new law protects the payers from aggressive billing by the terminating provider, it may result in a disruption in continuing services by the terminating provider. This rather imperfect model for continuity of care resulted from the fact that the legislature and the parties involved could not agree on a rate structure or methodology.

With respect to health care service plans but not health insurers, the bills establish new notice requirements whenever there is a pending provider termination. Specifically, plans must file with the Department of Managed Health Care a copy of the notice the plan intends to deliver to enrollees in the event of a provider termination 75 days prior to contract termination, and the approved notice must be provided to the enrollees at least 60 days prior to contract termination. This is in contrast to the prior requirement that plans notify members of a pending provider termination 30 days in advance.

Finally, the bills require healthplans to file with the Department of Managed Health Care a Continuity of Care policy that outlines how the plan will handle continuity issues for both new enrollees with continuity needs related to their prior plan and existing enrollees with continuity needs related to the termination of providers.

The bills amend Section 10133.56 of the Insurance Code and Sections 1373.65, 1373.95 and 1373.96 of the Health and Safety Code. They become effective January 1, 2004.

Hospital Charge Masters

AB 1627 (Frommer, Dem.-Los Angeles) addresses an issue relating to hospitals, but which could have significant impact on health insurance carriers and health plans. The bill deals with the hospital charge description master ("Charge Master"), the hospital's schedule of charges for services or items ("Billed Charges"). Critics alleged that some hospitals refused to reveal their Charge Masters to patients and payers. Further, some hospitals were accused of dramatic increases in Billed Charges over relatively short periods of time, without notice to anyone because Charge Master changes were not publicized.

From the payer's perspective, knowledge of the amounts in the Charge Master is important because many payer-hospital contracts call for payment at a percentage of Billed Charges. Moreover, there may be other instances where payers may be subject to paying Billed Charges. Thus, these portions of AB 1627, comprising new Sections 1339.50 to 1339.59, are called the "Payers' Bill of Rights."

New Section 1339.51 of the Health and Safety Code requires hospitals to make their Charge Masters available on their websites or in the hospitals, beginning July 1, 2004. Under new Section 1339.55, commencing July 1, 2004, hospitals will also be required to file the Charge Master annually with California's Office of Statewide Health Planning and Development ("OSHPD"). In addition, beginning the same date, each hospital is required to compile a list of the 25 services most commonly charged "to patients." This list will be made available on request and shall also be filed with OSHPD. OSHPD is also authorized to create a list of the ten most common Medicare diagnostic related groups ("DRGs") and the average charge for each DRG at each hospital, and to publish the list on its website.

2003 ANNUAL REVIEW OF KEY CASES AFFECTING

CALIFORNIA INSURERS

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COVERAGE

California Supreme Court

***MacKinnon v. Truck Insurance Exchange* (2003) 31 Cal. 4th 635, modified 31 Cal. 4th 1025: Absolute pollution exclusion applies only to "events commonly thought of as pollution."**

A person who lived in an apartment building died from exposure to pesticides that were sprayed in the building. Truck Insurance Exchange, the landlord's insurer, denied coverage pursuant to an absolute pollution exclusion in the landlord's Comprehensive General Liability ("CGL") policy. The exclusion barred coverage for discharge, dispersal, release or escape of pollutants. The policy defined "pollutants" to include irritants, contaminants and chemicals.

The Supreme Court agreed with Truck that the policy's definition of "pollutants" would include pesticides. But the court stated that the policy definition was too broad to provide a "meaningful" definition. The court observed that the policy definition could lead to absurd results in hypothetical situations, where the exclusion could be applied to events that are not commonly thought of as pollution. Accordingly, the court held that the exclusion only applied to "events commonly thought of as pollution," which do not include the intentional spraying of a pesticide. The court held this result was consistent with the reasonable expectations of the insured and the drafting history of the absolute pollution exclusion.

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Hameid v. National Fire Ins. of Hartford **(2003) 31 Cal. 4th 16: For purposes of "advertising injury" coverage, "advertising" means "widespread promotional activities directed to the public at large."**

In an action against an insurer for breach of the duty to defend, the Supreme Court held that an insurer under a general liability policy had no duty to defend a suit that accused the insured of misappropriating his competitor's client lists and using them in direct marketing. The court concluded that the insured's conduct did not amount to an "advertising injury" within the meaning of the insured's policy. The court adopted the approach taken by a majority of other courts, holding that an activity does not constitute "advertising" unless it involves widespread promotional activities directed to the public at large. Thus, direct marketing targeted towards a few customers does not constitute advertising.

Rosen v. State Farm General Ins. Co. **(2003) 30 Cal. 4th 1070: Insurer that provides coverage for actual collapse of a building is not required by public policy to provide coverage for imminent collapse.**

A homeowner sued his insurer, State Farm, alleging that decks on his property were in a state of imminent collapse and that State Farm had improperly denied his claim for the cost of repairing the decks. The homeowner's policy provided coverage for "collapse" of a building or part of a building and defined "collapse" as "actually fallen down or fallen into pieces." After a bench trial, the trial court decided that public policy required the insurer to provide coverage for imminent collapse, irrespective of the policy language.

The Court of Appeal affirmed. It agreed with State Farm that the plain language of the homeowner's policy provided coverage only for actual collapse. But it held that, as a matter of public policy, an insurer that provides coverage for collapse must also cover imminent collapse. Otherwise, the insured would be forced to await the actual collapse of a building to obtain coverage, which could lead to serious injury or loss of life.

The Supreme Court reversed, holding that where policy language is clear and unambiguous, the courts cannot not rewrite the coverage to conform to perceived public policy or the insured's expectations. Justice Moreno authored a concurring opinion, joined by Justices Kennard and Werdegar, disagreeing with the majority's sweeping statement that contracts should not be rewritten to conform with public policy, but he concluded that public policy did not justify rewriting the policy in this case.

California Court of Appeal

***Hartford Casualty Insurance Company v. Travelers Indemnity Company* (2003) 110 Cal. App. 4th 710: Insurer can enforce "excess only" clause that applies when insured is covered as an additional insured on another party's policy.**

In this dispute between two insurers over which one had the primary duty to defend and indemnify a common insured, the Court of Appeal ruled that one of the insurers could enforce a provision in its policy stating that its insurance would be excess only if the insured was covered as an additional insured in another policy. The court recognized that "excess only" clauses are disfavored and are generally not enforced. But the court held that the clause in this case was enforceable because it was narrowly tailored to a situation in which the parties would expect that insurance to be excess only.

***Gilmer v. State Farm Mutual Automobile Insurance Company* (2003) 110 Cal. App. 4th 416: Auto insurer is not required to provide coverage for permissive users of non-owned autos.**

This case addressed an insurer's obligations under an auto policy. The insured took a vehicle on a test drive and gave his friend permission to drive it. The friend then injured a third party. The third party argued that the insurer had a duty to provide coverage because the friend was a permissive user under the insured's policy. The Court of Appeal disagreed. The court acknowledged that Insurance Code section 11580.1, subdivision (b)(4), requires automobile insurers to provide coverage for certain permissive users. But the court pointed out that section 11580.1 requires coverage of permissive users only for vehicles "owned or leased" by the insured. It does not require insurers to cover permissive users when they are driving vehicles that are neither owned nor leased by the insured.

***Westoil Terminals Co., Inc. v. Industrial Indemnity Company* (2003) 110 Cal. App. 4th 139: Qualified pollution exclusion in CGL policy is enforceable.**

A company that was sued for causing groundwater contamination tendered defense of the action to its insurer under a CGL policy. The insurer refused to defend. The insured sued for breach of contract and bad faith. The Court of Appeal ruled in favor of the insurer, enforcing a policy exclusion that barred coverage for damages caused by pollution, except where the pollution occurred during a sudden and unexpected discharge during the policy period. Because the pollution here was not sudden or accidental and because it occurred before the policy period, the exceptions to the pollution exclusion did not apply, and coverage was barred.

The court rejected the plaintiff's reliance on *Montrose Chemical Corp. v. Admiral Ins. Co.* (1995) 10 Cal. 4th 645 (*Montrose II*), which adopted the "continuous trigger doctrine." Under that doctrine, a CGL insurer is liable for damages caused by an occurrence that took place before the policy period, so long as the injury continued into the policy period. The *Westoil* court held that *Montrose II* was inapplicable because the policy in that case did not contain the type of pollution exclusion at issue in *Westoil*.

United States Court of Appeals for the Ninth Circuit

***Khatchatrian v. Continental Casualty Company* (9th Cir. 2003) 332 F.3d 1227: Accidental death and dismemberment policy does not cover death by stroke, which is not an "accident" under California law.**

A beneficiary under an accidental death and dismemberment policy sued the insurer in federal court for breach of contract and bad faith, alleging improper denial of coverage for a death caused by a stroke. The district court granted summary judgment for the insurer, finding that the insured's death by stroke was not covered because it was not the result of an "accident" within the meaning of the policy.

The Ninth Circuit affirmed. It held that, under California insurance law, an injury is not the result of an "accident" unless some external force or event was a percipient cause of the injury. The court concluded that the insured's stroke, which was caused by the insured's chronic high blood pressure, was not an accident under this definition.

DUTY TO DEFEND

California Court of Appeal

***Modern Development Co. v. Navigators Insurance Co.* (2003) 111 Cal. App. 4th 932: Where policy covered insured's liability for bodily injury resulting from an "occurrence" defined as an "accident," insurer had no duty to defend insured who was sued for maintaining public restroom that was inaccessible to disabled persons in violation of Americans with Disabilities Act.**

The insured operated a swap meet. The insured was sued for maintaining public restrooms in a configuration that rendered them inaccessible to disabled persons, in violation of the Americans with Disabilities Act of 1990 and related California statutes. The insured's CGL insurer declined to defend or indemnify the insured on the ground the complaint did not allege any bodily injury or property damage caused by an "occurrence," defined as an "accident." The insured settled the action, then filed suit against the insurer for breach of contract, bad faith, and injunctive and restitutionary relief under Business & Professions Code section 17200. The trial court granted summary judgment for the insurer.

The Court of Appeal affirmed. It explained that injuries resulting from a disabled customer's inability to access restroom facilities and an owner's noncompliance with antidiscrimination laws "are not covered events . . . because they do not constitute 'accidents' or 'occurrences' as such terms are defined in the Policy. . . . Moreno's alleged injuries were caused by the architectural configuration of the Paramount Swap Meet and [the insured's] alleged failure to remove architectural barrier[s], not by an accident. The Swap Meet intended for the bathrooms to be configured as they were." (111 Cal. App. 4th at pp. 943-944.).

***Marie Y. v. General Star Indemnity Company* (2003) 110 Cal. App. 4th 928: Insurance Code section 533, which bars coverage for willful acts, precludes coverage for negligent acts that are "inextricably intertwined" with willful acts but does not necessarily preclude a duty to defend.**

In this breach of contract action, the Court of Appeal ruled that a professional liability insurer had no duty to defend or indemnify an insured dentist against claims that he molested his female patients while they were under anesthesia. Sexual molestation is uninsurable under Insurance Code section 533, which precludes coverage for willful acts. The court also held that the insurer had no duty to indemnify the insured against claims that he was vicariously liable for his assistant's negligent failure to prevent his misconduct. The court ruled that section 533 precludes coverage of negligent acts that are "inextricably intertwined" with a willful act. The court concluded that the alleged negligence of the dental assistants was "part and parcel" of the insured's design to commit misconduct and was therefore uninsurable.

Nevertheless, the court agreed with the trial court that the insurer had a duty to defend the insured against the vicarious liability claims because the policy expressly promised a defense against claims of willful misconduct to the extent they arose from a "dental incident." The court concluded that the purported negligence of the dental assistants constituted a "dental incident" within the meaning of the policy. Section 533 does not bar an insurer from defending an insured against allegations of willful acts, even though the insurer would be barred from indemnifying the insured if he is found liable.

***Uhrich v. State Farm Fire & Casualty Co.* (2003) 109 Cal. App. 4th 598: Insurer has no duty to defend insured against suit alleging both intentional torts and negligence where the underlying facts make clear that the insured's conduct was non-accidental.**

State Farm's insured, a psychologist, was sued by one of his former patients. The patient claimed that the insured had stalked her and had given false information about her to the police. The patient's complaint against the insured alleged both negligence and intentional torts. State Farm initially agreed to defend the insured under a reservation of rights but withdrew its defense when the insured pleaded guilty to "conspiracy to pervert and obstruct justice." The insured settled the case and assigned his bad faith chose in action to the patient, who sued State Farm. The trial court granted summary judgment for State Farm on the ground that the insured's conduct fell within the policy's professional duties and business operations exclusions.

The Court of Appeal affirmed. It held that the policy afforded no potential for coverage, regardless of any policy exclusions, because the policy covered only accidental losses. The court observed that the patient's pleadings in the underlying action showed that the insured's actions arose from a "malicious desire" and were therefore not accidental. Moreover, the court held that the insured could not reasonably expect State Farm to provide a defense; he acted with malice and should have understood he was not generating any loss within the meaning of the policy.

United States Court of Appeals for the Ninth Circuit

***Homedics v. Valley Forge Insurance Company* (9th Cir. 2003) 315 F.3d 1135: Patent infringement suit does not trigger insurer's duty to defend under CGL policy.**

The insured was sued by a competitor for patent infringement. The insured's CGL insurer declined to defend the action. The insured sued the insurer for breach of contract and for a declaration that the insurer was obligated to defend the patent infringement action. The district court ruled that the insurer had no duty to defend.

The Ninth Circuit affirmed. It rejected the insured's argument that the patent infringement suit was potentially covered under the "advertising injury" provision in the policy, which provided coverage for injury arising out of "misappropriation of advertising ideas or style of doing business." The court held that no reasonable insured could expect this coverage provision to extend to patent infringement actions. In reaching this holding, the court relied on *Mez Industries Inc. v. Pacific Nat. Ins. Co.* (1999) 76 Cal. App. 4th 856, which found no potential for coverage under an "advertising injury" provision for an action alleging inducement of patent infringement. The Ninth Circuit in *Homedics* said the reasoning of *Mez* offered no basis for distinguishing between actions for patent infringement (as in *Homedics*) and inducement of patent infringement (as in *Mez*).

The court also rejected the insured's argument that the "personal injury" provision of the CGL policy could potentially cover the patent infringement action. That provision provided coverage for, inter alia, personal injury arising out of disparagement of an organization's products. The court held that no reasonable person could conclude that the underlying patent infringement action alleged disparagement of the plaintiff's product.

BAD FAITH

California Court of Appeal

***Diamond Woodworks, Inc. v. Argonaut Insurance Company* (2003) 109 Cal. App. 4th 1020: Third-party beneficiary of workers' compensation policy can sue insurer for bad faith.**

Argonaut Insurance issued a workers' compensation policy to Builders Staff Corporation (BSC), which leased employees to Diamond Woodworks (Diamond). Argonaut issued certificates of insurance listing Diamond as an insured, with the caveat that only BSC's employees working at Diamond's jobsite were covered under the policy. BSC and Argonaut understood that Diamond itself was not insured. A worker at Diamond's jobsite, who was slated to become a BSC employee but had not been formally hired by BSC, was injured on the job. Because the worker was not a BSC employee, Argonaut denied his claim for workers' compensation benefits. He then sued Diamond for failing to maintain workers' compensation insurance. Diamond tendered its defense to Argonaut, but Argonaut refused to defend. Eighteen months into the litigation, Argonaut negotiated a settlement with the employee.

Diamond sued Argonaut, contending that Diamond was insured under Argonaut's policy and Argonaut should have defended the lawsuit. Diamond also argued that, if it was not insured, then Argonaut committed fraud by leading Diamond to believe it was in fact insured. A jury ruled in favor of Diamond and awarded damages for breach of contract, bad faith, and fraud.

The Court of Appeal affirmed the imposition of liability. It held that Diamond was a third-party beneficiary of the insurance policy because the contract was expressly made for the benefit of the companies who leased workers from BSC. It further held that, as a third party beneficiary, Diamond could sue Argonaut for bad faith. However, the court concluded that both the compensatory and punitive damages were excessive.

***Morris v. Paul Revere Life Ins. Co.* (2003) 109 Cal. App. 4th 966: As a matter of law, insurer did not act in bad faith by withholding policy benefits where coverage issue was purely legal and courts in California and elsewhere were divided on the issue.**

The insurer issued a disability policy providing, on the one hand, that coverage would be limited to disability from diseases first manifesting after the policy's issue date and, on the other hand, that no claim for a disability starting more than two years after the issue date would be contested or denied on the ground a sickness or physical condition not excluded by name had existed before the issue date. More than two years after the issue date, the insured submitted a claim for benefits based on disability resulting from multiple sclerosis. After paying benefits for about six months, the insurer denied further benefits on the ground the disease had first manifested itself before the policy's issue date.

The insured sued the insurer to obtain the benefits he claimed were owed. The insured further alleged that, in light of the two-year incontestability clause, the insurer had acted in bad faith in denying benefits. The trial court granted summary judgment for the insurer on the ground the insured's disease was not covered because it had manifested itself before the policy's issue date. Having found no coverage, the court did not address the allegations of bad faith.

While the insured's appeal was pending, the California Supreme Court addressed the identical issue in another case. (*See Galanty v. Paul Revere Life Ins. Co.* (2000) 23 Cal. 4th 368.) The Supreme Court noted that the one published California opinion to address the issue had offered no useful discussion and that two other California appellate courts had decided the issue in the insurer's favor, including the lower court in *Galanty*. The Supreme Court also noted that courts elsewhere were divided on the issue. The court sided with the insured, holding that the two-year incontestability clause, which was mandated by statute, was inconsistent with the provision that allowed the insurer to deny coverage for any disability caused by a disease that had manifested prior to the policy's issue date. Therefore, the insured was entitled to coverage as a matter of law once the two-year period lapsed, notwithstanding evidence of premanifestation.

In light of the Supreme Court's decision, the parties in Morris stipulated to reversal of the judgment on coverage. The matter was remanded to the trial court for

resolution of the insured's bad faith claim. The trial court granted summary judgment for the insurer, agreeing with its contention "that in light of the substantial split of authority nationwide, and the relative dearth of case law in California prior to *Galanty*, the issue was not sufficiently settled to render its argument unreasonable." (109 Cal. App. 4th at pp. 972-973.)

The Court of Appeal affirmed. It held that the insurer's legal position had been objectively reasonable in light of the unsettled law that existed before the Supreme Court decided *Galanty*. In response to the insured's argument that the law was settled before *Galanty*, the court observed that "the very fact that our Supreme Court accepted *Galanty* for review suggests it did not consider the issue argued by [the insurer] to have been settled." (109 Cal.App.4th at p. 975.) The court also noted that, where the coverage issue turns on an analysis of a legal point, "the fact that a court had interpreted that law in the same manner as did the insurer, whether before or after, is certainly probative of the reasonableness, if not necessarily the ultimate correctness, of its position." (Id. at p. 976.)

OTHER SIGNIFICANT INSURANCE CASES

United States Supreme Court

***American Insurance Association v. Garamendi* (June 23, 2003, 02-722) ___ U.S. ___ [123 S. Ct. 2374, 156 L. Ed. 2d 376]: Federal law preempts California's Holocaust Victim Insurance Relief Act.**

The federal government established a program to resolve claims by Holocaust survivors and their heirs against companies that did business in Germany during the Nazi era. As part of this program, the International Commission on Holocaust Era Insurance Claims was designated to provide information about and settlement of unpaid insurance policies.

The California Legislature independently passed the Holocaust Victim Relief Act (HRVA), which requires insurers doing business in California to provide information about all policies sold in Europe between 1920 and 1945, including policies by any of the insurer's "related" entities. A group of insurers filed suit in federal court to invalidate the HRVA. The district court ruled in their favor but the Ninth Circuit reversed.

The Supreme Court reversed the Ninth Circuit and struck down the HRVA. It held that the HRVA conflicted with the federal program for resolving Holocaust-era insurance claims and conflicted with the President's foreign policy.

***Kentucky Assn. of Health Plans v. Miller* (2003) ___ U.S. ___ [123 S. Ct. 1471, 155 L. Ed. 2d 468]; *Rush Prudential HMO, Inc. v. Moran* (2002) 536 U.S. 355 [122 S. Ct. 2151, 153 L. Ed. 2d 375]: ERISA does not preempt state laws that impose procedural requirements on HMOs.**

In *Rush*, an HMO denied a participant's request to have a surgical procedure on the ground that it was not medically necessary. The participant made a written demand for an independent medical review as required by the Illinois HMO Act. The HMO refused the demand and the participant sued to compel compliance with the Act. The district court ruled that the Illinois HMO Act was preempted by ERISA. The Seventh Circuit reversed and the Supreme Court granted certiorari.

The Supreme Court affirmed the Seventh Circuit, holding that ERISA does not preempt the Illinois HMO Act. The Court based its analysis on the McCarran-Ferguson Act, which provides that no act of Congress shall be construed to invalidate any state law enacted for the purpose of regulating insurance. The Court said that, although HMOs provide healthcare, they also provide insurance. Thus, the Illinois HMO Act was enacted for the purpose of regulating insurance within the meaning of the McCarran-Ferguson Act.

In *Miller*, a group of HMOs sued to invalidate the "Any Willing Provider" provisions of the Kentucky Health Care Reform Act, which prohibited HMOs from discriminating against any providers willing to meet the terms and conditions for participation in an HMO plan. The HMOs argued that ERISA preempted the "Any Willing Provider" rules. The district court disagreed and granted summary judgment for the defendant. The Sixth Circuit affirmed and the Supreme Court granted certiorari.

The Supreme Court reversed the Sixth Circuit, concluding that the "Any Willing Provider" provisions are saved from preemption by ERISA's savings clause, 29 U.S.C. § 1142(b)(2)(A), which states that ERISA does not preempt laws which regulate insurance. The Court said the "Any Willing Provider" provisions regulate insurance because they are specifically directed toward insurers and they significantly affect the risk pooling arrangement between the insurer and the insured.

The *Miller* Court criticized its earlier holding in *Rush*. *Miller* said *Rush* created confusion by analyzing ERISA preemption issues under McCarran-Ferguson case law, and provided "wide opportunities for divergent outcomes." Accordingly, the court announced a "clean break" from the McCarran-Ferguson factors, and set forth two requirements for determining whether a state law regulates insurance within the meaning of the ERISA savings clause: (1) the law must be specifically directed toward entities engaged in insurance, and (2) the law must substantially affect the risk pooling arrangement between insurer and insured.

California Court of Appeal

***Century Surety Company v. United Pacific Insurance Company* (2003) 109 Cal. App. 4th 1246: Primary insurer cannot use "other insurance" clause to completely eliminate coverage obligation.**

Four different insurers provided primary insurance to a common insured over a five year period. Three of the insurers issued policies stating that they would share defense and indemnity obligations with any other primary insurers that covered the same loss. One of the insurers, Century Surety Company, issued a policy stating that it would not share defense and indemnity obligations with any other primary insurers, and that its coverage would become "excess only" if any other primary insurers covered the same loss.

The insured suffered a loss that potentially triggered coverage under all four policies. Citing its "excess only" clause, Century informed the insured that it would only respond for defense or indemnity in the event that the coverages of the other policies were exhausted. Century then sued the other insurers for declaratory relief. The trial court ruled in favor of the other insurers and Century appealed.

The Court of Appeal affirmed. It first noted that Century was a primary insurer, not an excess insurer. The court stated that true "excess" insurance policies provide coverage only when other insurance is exhausted. Here, Century's policy provided primary coverage when no other insurance was present, and it purported to become excess only when other insurance was available. The court concluded that, for public policy reasons, a primary insurer cannot avoid its coverage obligations through an "excess only" clause but must share defense and indemnity obligations with other primary insurers on a pro rata basis.

***Kavruck v. Blue Cross of California* (2003) 108 Cal .App. 4th 773: Health insurer cannot convert "entry age" policy to "attained age" policy, even when policy expressly provides that it can be modified on 30 days' written notice.**

Blue Cross issued a health insurance policy stating that premiums would be based on the subscriber's initial enrollment age. Ten years later, Blue Cross stopped selling such "enrollment age" policies and transferred all of its subscribers to policies for which premiums were based on the subscriber's age at the time of renewal. One of the subscribers sued Blue Cross for breach of contract, bad faith, fraud, negligent misrepresentation, and unfair competition. The trial court granted summary judgment for Blue Cross, citing a policy provision that allowed Blue Cross to modify the contract on 30 days' notice.

The Court of Appeal reversed. It said the "enrollment age" provision in the original policy was an implied promise that the insured would be forever rated based on her initial enrollment age unless she changed the type of her contract. The court found that this implied promise governed over the express provision stating that Blue Cross could modify the policy on 30 days' notice. The court supported its holding by referring

to parol evidence, including a brochure for the original policy, which expressly stated that the insured's age rating would not change unless she changed the type of her contract.

People ex rel. Allstate Ins. Co. v. Weitzman **(2003) 107 Cal. App. 4th 534: Insurer can pursue qui tam action against insurance fraud ring, even if another insurer previously filed a qui tam action against the same defendants for similar misconduct.**

Allstate Insurance Company brought a qui tam action seeking to recover proceeds it paid to a group of defendants who ran an insurance fraud ring. The trial court dismissed the action under Insurance Code section 1871.7, subdivision (h)(2), which bars insurers from pursuing qui tam actions based on allegations that were previously disclosed in other proceedings. The court ruled that Allstate's action was barred because the defendants' insurance fraud ring had already been exposed in a previous qui tam action by Fidelity Insurance Company.

The Court of Appeal reversed. It held that Allstate could pursue its own action because the uncontroverted evidence showed that Allstate learned of the defendants' fraud from its own investigation, not from the Fidelity action. Moreover, Allstate's investigation disclosed evidence of 99 staged collisions and 326 fraudulent claims that were not involved in the Fidelity action.

Adams v. Explorer Ins. Co. **(2003) 107 Cal.App.4th 438: Notice of cancellation of auto policy remains effective even if insured adds new vehicles to the policy after the notice but before the cancellation date.**

Explorer Insurance issued an auto policy covering multiple vehicles owned by the insured. In June 1999, the insured failed to make a premium payment. On July 6, 1999, Explorer sent him a cancellation notice, informing him that his policy would be cancelled on July 19, 1999, if he did not pay.

On July 13, 1999, plaintiff submitted a request to his agent to delete two vehicles from the policy and to add two other vehicles. He submitted a payment to cover the additional premium for the new vehicles, but he did not pay his overdue premiums.

On July 19, Explorer cancelled the policy. On July 20, it issued a "Cancellation Memo" advising the insured that his policy had been cancelled and that he could reinstate his policy — with a lapse in coverage — by paying the overdue amount.

On August 12, the insured was involved in an accident while driving one of the new vehicles that he had added to the policy. On August 13, Explorer received a payment from plaintiff for the overdue amount. Explorer reinstated the policy, but refused to cover the August 12 accident because the insured's policy had lapsed from July 19 to August 13. The insured sued for breach of contract, bad faith, and unfair business practices. The trial court granted summary judgment for Explorer.

The Court of Appeal affirmed. It rejected the insured's argument that the July 6 cancellation notice was not effective with respect to the vehicle he was driving at the time of the accident, which he added after July 6. The court held that the addition of the new vehicle did not affect the validity of the previous cancellation notice, nor did it require a new cancellation notice. The court also rejected the insured's argument that the cancellation notice was ineffective because the amount of the overdue premiums changed after the notice was issued. Following the reasoning of two New York cases, the court noted that cancellation notices need not state the amount in arrearage; therefore, if they do state an amount, any error in the amount cannot affect the validity of the notice.

***Scognamillo v. Herrick* (2003) 106 Cal. App. 4th 1139: Default judgment caused by insurer's inexcusable neglect cannot be vacated.**

A driver insured by United States Fidelity and Guaranty Company (USF&G) was sued over his involvement in a traffic accident. He forwarded the summons and complaint to his insurance broker, who in turn notified Ward North America (Ward), a third party administrator for USF&G. Ward failed to answer the complaint or otherwise defend against the action. Eventually, a default was entered against the insured. The insured moved to set aside the default, providing a declaration from a claims manager at Ward explaining that Ward's failure to defend was due to negligence by one of its office clerks. The trial court concluded that the declaration failed to demonstrate excusable neglect and denied the motion to set aside the default. The court then awarded damages to the plaintiff, including the costs of two future surgeries and future lost wages resulting from those surgeries.

The Court of Appeal affirmed in part and reversed in part. It acknowledged that the default was entirely the fault of the insurer, not the insured. But the court held that the insured needed to demonstrate excusable neglect by his insurer to set aside the default. The court expressly disagreed with *Rogalski v. Nabers Cadillac* (1992) 11 Cal. App. 4th 816, which granted relief from a default that was entirely the fault of the insurer. The court instead relied on the earlier case of *Don v. Cruz* (1982) 131 Cal. App. 3d 695, which refused to grant relief to an insured based on the inexcusable neglect of his insurer. The court concluded that Ward's neglect was inexcusable because Ward failed adequately to explain why it did not respond to repeated notices from the insured's broker that an active case was pending against the insured.

Although the court refused to set aside the default, it reversed the judgment on the ground of excessive damages. The court concluded that the trial court improperly awarded speculative damages for future medical procedures and failed to reduce to present value the award for future lost wages resulting from past medical procedures.

Mackey v. Bristol West Ins. Service of Cal., Inc. **(2003) 105 Cal. App. 4th 1247: Notice of cancellation for nonpayment is not valid if issued before insured's premium payment is due.**

Insurance Code section 662 requires insurers to give at least 10 days' notice before canceling a policy for nonpayment of premiums. Coast National Insurance Company attempted to satisfy this requirement by sending a cancellation notice along with its invoice for premium payments. The notice warned insureds that if they did not pay their premiums on time, Coast would cancel their policies the next day.

The insured in this case received Coast's standard notice 13 days before his payment was due. He did not pay his premiums on time and Coast cancelled his policy the next day. Two weeks later, he was involved in an accident. He paid his overdue premiums and filed a claim. Coast denied the claim, saying it had cancelled the policy before the accident. The insured sued for breach of contract and bad faith. The trial court sustained Coast's demurrer without leave to amend and dismissed the action with prejudice, based on Coast's cancellation of the insured's policy.

The Court of Appeal reversed. It held that Coast's notice failed to satisfy the requirements of section 662. The court stated that the obvious intent of section 662 was to require insurers to send out a 10-day notice after an insured missed a payment, giving the insured a 10-day period to cure the default or secure other insurance. Coast's cancellation of the insured's policy was therefore ineffective because cancellation can only be accomplished after strict compliance with section 662. Accordingly, the court reversed the judgment of dismissal and remanded the case to the trial court for further proceedings.

Juarez v. 21st Century Ins. Co. **(2003) 105 Cal. App. 4th 371: If insured is represented by counsel, insurer is not required to notify insured of one-year suit provision applicable to uninsured motorist claims.**

21st Century's insured was injured in a collision with an uninsured motorist. 21st Century denied the insured's claim because he was driving a non-covered vehicle at the time of the accident. The insured sued for breach of contract and bad faith. 21st Century moved for summary judgment, citing Insurance Code section 11580.2, which provides that an insured's cause of action for denial of uninsured motorist benefits does not accrue unless one of three actions is taken within a year of the accident: (1) a lawsuit is filed against the uninsured motorist, (2) an agreement is reached as to the amount due under the policy, or (3) the insured institutes arbitration proceedings. The insured conceded that none of these three events had occurred within a year of the accident. Accordingly, the trial court granted summary judgment.

The Court of Appeal affirmed. It rejected the insured's argument that section 11508.2 could not be enforced because 21st Century was required by California Code of Regulations, title 10, section 2695.4, to give notice of any time limits applicable to the insured's claims. The court held that the regulatory provision conflicted with section 11580.2, subdivision (k), which specifically provides that the insurer need not give such

notice when the insured is represented by counsel. The court held that section 11580.2, as a legislative enactment, overrides any inconsistency presented by the regulations. Moreover, section 11580.2 is specific to uninsured motorist coverage, and therefore governs over the more general provision in the regulations.

United States Court of Appeals for the Ninth Circuit

Foltz v. State Farm Mutual Automobile Ins. Co. **(9th Cir. 2003) 331 F.3d 1122: Intervenor can gain access to sealed documents unless there is a compelling reason not to allow access.**

State Farm was sued in federal court for allegedly conspiring with a medical utilization review company to defraud State Farm's insureds of personal injury protection under their automobile policies. During discovery, the district court entered several protective orders at State Farm's request, prohibiting disclosure of confidential information disclosed during discovery. After four years of litigation, the parties settled and obtained an order sealing the entire court file except for a few specified documents.

Several third parties, including plaintiffs in another similar case against State Farm, intervened in the case and asked for access to the protected and sealed documents. The district court denied their request and they appealed.

The Ninth Circuit reversed. First, it held that the district court erred in granting the protective orders with respect to discovery documents, because State Farm failed to show "good cause" by identifying specific confidential information contained in the protected documents. Second, the court held that the district court abused its discretion by refusing to modify the protective order to make documents available to the intervenors who were suing State Farm in related litigation; the district court failed to consider whether the protected documents are relevant to the collateral litigation. Finally, the Ninth Circuit held that the district court erred in sealing the entire court file, because the strong presumption of public access to court records outweighed the need for confidentiality. To the extent the documents contained confidential information of third parties, those portions of the documents could have been redacted.

Employers Insurance of Wausau v. Granite State Insurance Company **(9th Cir. 2003) 330 F.3d 1214: Subrogation action is not subject to two-year limitation period for equitable actions; primary insurer's coverage for single occurrence is not exhausted where damage in any given year never exceeds annual policy limit.**

California Water Services (CWS) purchased insurance from Employers Insurance of Wausau (Wausau) and Granite State Insurance Company (Granite). The Wausau policy had a limit of $2 million per year for each occurrence. The Granite policy was excess to the Wausau policy, with a limit of $5 million per year per occurrence.

Over a period of several years, a group of homeowners experienced property damage caused by a landslide that occurred when CWS' underground waterlines ruptured. The homeowners sued CWS. Wausau defended the action, ultimately settling the homeowners' claims for $7.75 million. Wausau then brought a subrogation action

against Granite, seeking $5 million. The trial court granted summary judgment in favor of Wausau, but later vacated the judgment on the ground that Wausau's claim was barred by the two-year statute of limitations on equitable actions.

The Ninth Circuit reversed the trial court's ruling on the statute of limitations issue, rejecting the trial court's conclusion that subrogation actions are equitable in nature and are therefore subject to the two-year limitations period. The Ninth Circuit held that, under California law, a subrogee insurer is subject to the same statute of limitations that would have been applicable had the insured brought suit in his or her own behalf. Because an action by CWS against Granite would have been subject to a four-year statute of limitations for suits on written instruments, and because Wausau filed suit within four years, Wausau's subrogation action was timely.

After concluding that the trial court erred in vacating the original judgment, the Ninth Circuit then reversed the original judgment. It held the trial court should have granted summary judgment to Granite because Granite's policy was excess only, and Wausau had not proven that the amount of the claims exceeded the limits of Wausau's primary policy. Although the $7.75 million settlement exceeded the $2 million annual limit on Wausau's policy, the damage in any one year never exceeded $2 million. Accordingly, no liability attached under Granite's policy.

Campanelli v. Allstate Life Ins. Co. **(9th Cir. 2003) 322 F.3d 1086: Code of Civil Procedure section 340.9 (SB 1899) is constitutional and revives earthquake claims that were pending on appeal as of January 1, 2001.**

A group of homeowners who suffered damage to their homes during the 1994 Northridge earthquake made claims to Allstate, their insurer. Allstate paid the claims. In September 1998, the homeowners sued Allstate for allegedly using fraudulent engineering reports during the claims adjustment process. The district court granted summary judgment for Allstate, finding that plaintiff's claims were barred by the one-year limitations period set forth in their policies. The insureds appealed. While their appeals were pending, California Code of Civil Procedure section 340.9 became effective, reviving certain time-barred claims arising from the Northridge earthquake.

The Ninth Circuit reversed, finding that section 340.9 revived plaintiff's untimely claims. The court noted that section 340.9 does not revive claims that were "litigated to finality" prior to January 1, 2001. But the court concluded that the homeowners' claims in this case, although they were resolved by a summary judgment prior to January 1, 2001, were not "litigated to finality" within the meaning of section 340.9 because they were still pending on appeal as of that date. The court also upheld the constitutionality of section 340.9 under the contract and due process clauses of the federal and California Constitutions, as the California Court of Appeal had previously done in *Hellinger v. Farmers Group, Inc.* (2001) 91 Cal. App. 4th 1049 and *20th Century Ins. Co. v. Superior Court* (2001) 90 Cal. App. 4th 1247.